DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SHO #03-001

June 20, 2003

Dear State Health Official,

The Centers for Medicare & Medicaid Services (CMS) is pleased to solicit proposals from states interested in participating in the third year of the Payment Accuracy Measurement (PAM) Project. As both a Government Performance and Reporting Act (GPRA) goal and a requirement of the Improper Payments Information Act of 2002 (Public Law 107-300), CMS is committed to developing a methodology that can be used to estimate payment accuracy for both Medicaid and the State Children's Health Insurance Program (SCHIP) at the state and national levels. We anticipate implementing PAM on a national basis after the third year, in accordance with the Improper Payments Information Act of 2002. Therefore, we strongly encourage state participation in this final year of refining the PAM methodology.

Working with our technical consultant, The Lewin Group, and the many states that have participated in the PAM Project, we have developed the CMS PAM Model. This model is designed to estimate payment accuracy in the Medicaid and SCHIP programs. Importantly, the Improper Payments Information Act of 2002 and related OMB guidelines define erroneous payments to include overpayments, underpayments, and payments made to ineligible beneficiaries. Accordingly, the CMS PAM Model has been modified for the third year to account for improper payments attributable to all three of these factors.

During the third year, we are encouraging states to volunteer to pilot test the CMS PAM Model in their Medicaid and SCHIP programs. To accommodate the diversity among states, provide maximum flexibility, and expand participation, we are offering each state the opportunity to participate in any or all aspects of the PAM pilot test program relevant to the state. The state may choose to pilot test the model in either its Medicaid or its SCHIP program, or in both programs. Within Medicaid, the state may choose to test the fee for service (FFS) component, the managed care (MC) component, or both. Similarly, in SCHIP, states can pilot test the model in either their Medicaid expansion, stand alone, or both components of their program. Naturally, we encourage the states to participate in all relevant areas, but we recognize that the state may choose selective participation. Because we are planning to finalize the specifications for the CMS PAM Model during the third year, states are asked to adhere to the required procedures and guidelines as detailed in the model.

The third year of the project builds directly on experience gained in the first two rounds of pilots. We have refined the PAM model to incorporate lessons learned in those pilots and to accommodate the Improper Payments Information Act of 2002. As in the past 2 years, states will

receive 100 percent Federal funding for all expenses incurred through participation in the PAM Project; therefore, no state financial contribution will be required. States will be supported through a combination of Federal financial participation and Health Care Fraud and Abuse Control (HCFAC) grant funding as reimbursement for what would otherwise be the state share. The first two rounds were financed in part with FY 2001 and 2002 HCFAC grant funds. For the third year, CMS has slightly more than $6.5 million in HCFAC funds to support state PAM Projects in the third year, and is interested in expanding the project to up to 25 states.

Applications for the third year of the PAM Project, beginning September 30, 2003, are due 60 calendar days from the date of this letter. Applications may be submitted by the state Medicaid agency, the agency that administers the SCHIP program, or another state agency in partnership with the Medicaid agency. Participation is open to all states, regardless of prior participation in the project. States that participated in previous years of the PAM Project must submit a new application to participate in the third year. CMS anticipates announcing the awards within 45 calendar days of receiving the applications.

CMS encourages your state's participation in the third year of the PAM Project. The Improper Payments Information Act of 2002 requires that CMS estimate improper payments in both Medicaid and SCHIP, and take action to reduce them. The Federal Government and the states have a strong financial interest in ensuring that claims are paid accurately. Because no systematic means of measuring payment accuracy at the state and national levels currently exists, we must work in partnership to further develop and refine the CMS PAM Model in order to identify program vulnerabilities and help target corrective actions.

Please note that follow-up action to recover overpayments identified in the third year PAM Project is encouraged, but is at the discretion of the participating states. Also, the collection and review of protected health information contained in individual-level medical records for payment review purposes, as required by the PAM Project, is permissible by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing Privacy Rule regulations at 45 CFR Parts 160 and 164.

The Program Announcement is enclosed. If you have questions or need additional assistance, please contact the PAM Project Officer, Wayne A. Slaughter at (410) 786-0038 or e-mail: wslaughter@cms.hhs.gov.

I look forward to joining with you to enhance the effectiveness of the Medicaid program. Our success will be in meeting the needs of our beneficiaries while better ensuring the financial integrity of the program.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

State Program Integrity Directors

Kathryn Kotula
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director
Association of State and Territorial Health Officials

Jim Frogue
Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Mathews
Senior Health Policy Analyst
Council of State Governments

Executive Summary

Medicaid and SCHIP Payment Accuracy Measurement (PAM) Demonstration Project CFDA – 93.779

The Centers for Medicare & Medicaid Services (CMS) is soliciting proposals from states to participate in the third year of the PAM Project, starting September 30, 2003. Approximately $6.5 million in Health Care Fraud and Abuse Control (HCFAC) program funding has been made available for the third year, in order to expand the PAM Project to up to 25 states. The purpose of the third year of this cooperative agreement is to further refine and pilot test the CMS PAM Model, which has been designed to measure the accuracy of Title XIX Medicaid and Title XXI State Children's Health Insurance Program (SCHIP) payments in both FFS and MC programs at the state and national levels. CMS intends to produce the final specifications for the CMS PAM Model during the third year of the pilot project with the expectation that the model thereafter will be implemented nationwide.

During the first year of the PAM Project, nine states were awarded grants from CMS to develop and pilot test various methodologies that would produce state-specific payment accuracy estimates. These methodologies provided CMS with a number of diverse approaches to measuring Medicaid payment accuracy at the state level. Incorporating best practices from these nine pilot projects, and groundbreaking efforts by states such as Illinois, Texas, and Kansas, CMS developed the CMS PAM Model. The CMS PAM Model has been designed to produce a state-specific payment accuracy rate that is within +/- 3 percent of the true population accuracy rate with 95 percent confidence. Through weighted aggregation, the state-specific estimates can be used to make payment accuracy estimates for the Medicaid and SCHIP programs at the national level. The CMS PAM Model has been designed to provide CMS with both the uniformity and precision to estimate payment accuracy at the national level, while maintaining sufficient flexibility to enable states to produce state-specific estimates.

During the second year of the PAM Project, 12 states are testing the CMS PAM Model in their respective FFS and/or MC programs. Of these 12 states, 7 are testing the FFS component of the model, 4 are testing both the FFS and MC components, and 1 is testing only the MC component. The CMS PAM Model was recently modified to comply with the requirements of the Improper Payments Information Act of 2002, by also including improper payments attributable to underpayments and payments made on behalf of ineligible beneficiaries. A majority of the states participating in the second year of the PAM Project are pilot testing these new modifications to the model.

As noted above, in the third year of the PAM Project, CMS plans to award grants to up to 25 states. We are also anxious to pilot test the CMS PAM Model in the SCHIP as well as in the Medicaid program. In order to accommodate the diversity among states, provide maximum flexibility, and expand participation, we are encouraging states to participate in any or all aspects of the project relevant to the state. Therefore, states may choose to pilot test the model in either their Medicaid or SCHIP programs, or the state may pilot test the model in both programs. Furthermore, within the Medicaid program, states may choose to test the model in the FFS, MC,

or in both components of their program. Similarly, in SCHIP, states can test the model in the Medicaid expansion, stand alone, or in both components of their program. We encourage states to pilot test the model in all relevant aspects of their Medicaid and SCHIP programs, although we recognize that states may prefer to remain selective with regard to participation in the project. Because we are planning to finalize the specifications for the CMS PAM Model during the third year, states are asked to adhere to the required procedures and guidelines as detailed in the model.

As in the past two years, states will receive full Federal funding for all expenses incurred through participation in the PAM Project. State costs will be reimbursed through a combination of Federal financial participation (FFP) and HCFAC program grant funding that covers what would normally be the state share. No state financial contribution will be required since the PAM Project will be 100 percent Federally funded.

Please note that follow-up actions taken by the states in response to specific overpayments and underpayments identified in the PAM Project is at the discretion of the states. Also, the collection and review of protected health information contained in individual-level medical records for payment review purposes, as required by the PAM Project, is permissible by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and implementing Privacy Rule regulations at 45 CFR Parts 160 and 164.

This solicitation is for the third year of the PAM Project. Applications are due no later than 60 calendar days from the date of the solicitation. States that have participated in the PAM Project are encouraged to apply for the third year. Applications will be accepted from the state Medicaid agency, the state agency that administers SCHIP, or from another relevant state agency (e.g., Auditor, Comptroller) if working in collaboration with the Medicaid agency. Proposals are being solicited under the authority of section 402(a)(l)(J) of the Social Security Act Amendments of 1967. For purposes of this cooperative agreement, "state" is defined as each of the 50 states and the District of Columbia.

CMS anticipates announcing the awards within 30 calendar days of receiving the applications. The funding period is for 12 months from September 30, 2003 through September 29, 2004.

Medicaid and SCHIP Payment Accuracy Measurement (PAM)
Demonstration Project
CFDA – 93.779

Sponsored by:
The Centers for Medicare & Medicaid Services

I. Purpose

The purpose of the Centers for Medicare and Medicaid Services' (CMS) Payment Accuracy Measurement (PAM) Project is to explore the feasibility of conducting payment accuracy measurement studies in all states using a single methodology that can produce both state-specific and national level Title XIX Medicaid and Title XXI State Children's Health Insurance Program (SCHIP) payment accuracy estimates.

Essentially, payment accuracy measurement enables government to identify the extent of problems in the claims payment system, study the causes of these problems, and better focus and strengthen internal controls. At the state level, states will be able to produce a payment accuracy estimate for their Medicaid and SCHIP programs and identify existing and perhaps emerging vulnerabilities that can then be more effectively targeted with the appropriate corrective actions. At the national level, CMS will be able to estimate the size of potential problems and produce an overall payment accuracy estimate for the Medicaid and SCHIP programs.

CMS is soliciting proposals from states to participate in the third year of the PAM Project. Approximately $6.5 million in Health Care Fraud and Abuse Control (HCFAC) program funding has been made available for the third year, in order to expand the PAM Project to up to 25 states. The purpose of the third year of this cooperative agreement is to further refine and pilot test the CMS PAM Model, which has been designed to measure the accuracy of Medicaid and SCHIP payments in both FFS and MC programs at the state and national levels. CMS intends to produce the final specifications for the CMS PAM Model during the third year of the pilot project with the expectation that the model thereafter will be implemented nationwide.

As in the past 2 years, states will receive full Federal funding for all expenses incurred through participation in the PAM Project. State costs will be reimbursed through a combination of Federal financial participation (FFP) and HCFAC program grant funding that covers what would normally be the state share. No state financial contribution will be required since the PAM Project will be 100 percent Federally funded.

II. Background

The Improper Payments Information Act of 2002 (Public Law 107-300) (the Act) directs each executive agency, in accordance with the Office of Management and Budget (OMB) guidance, to review all of its programs and activities annually, identify those that may be susceptible to significant improper payments, estimate the annual amount of improper payments, and submit those estimates to Congress before March 31 of the following applicable year.

The Act requires each Federal agency, for each program or activity with estimated improper payments exceeding $10 million, to provide with the estimate a report on agency actions to reduce improper payments, including: (1) a discussion of the causes of the improper payments and the results of the actions taken to address those causes; (2) a statement of whether the agency has the information systems and other infrastructure; and (3) a description of the steps the agency has taken to ensure that managers are held accountable for reducing improper payments.

In Exhibit 57B of OMB Circular A-11, programs for which improper payment information is requested within the Department of Health and Human Services include: Head Start, Medicare, Medicaid, Temporary Aid to Needy Families (TANF), Foster Care Title IV-E, SCHIP, and the Child Care and Development Fund.

In order to comply with the definitions of improper payments cited in the Act and OMB Circular A-11, Section 57, Federal agencies are expected to provide estimates of improper payments, defined as: (a) any payment that should not have been made or that was made in an incorrect amount, including both overpayments and underpayments, under statutory, contractual, administrative, or other legally applicable requirements; and (b) payments made to an ineligible recipient, any duplicate payments, payments for services not received, and any payment that does not account for credit for applicable discounts.

CMS has been estimating improper payments in the Medicare program since 1996 as part of the Chief Financial Officer's (CFO) Audit conducted annually by the Office of Inspector General (OIG). The Comprehensive Error Rate Testing (CERT) Program, which is being implemented in phases, is scheduled to assume responsibilities for producing the annual improper payment estimate for the Medicare program beginning in FY 2003.

In fiscal year (FY) FY 2000, CMS adopted a Government Performance Reporting Act (GPRA) goal to explore the feasibility of developing a methodology to estimate improper payments for the Medicaid program. During the year, the Center for Medicaid and State Operations (CMSO) initiated the Medicaid Payment Accuracy Measurement (PAM) Project. Prior to the first year of the PAM Project only three states, Illinois, Texas, and Kansas, had attempted to estimate payment accuracy for the Medicaid program at the state level, and no model had been developed to estimate payment accuracy at the national level.

In July of 2001, CMS formally solicited states to participate in the first year of the PAM Project. Using a combination of FFP and Health Care Fraud and Abuse Control (HCFAC) grant funds, nine states were awarded grants to develop and pilot test various methods for measuring the accuracy of Medicaid payments. These nine states included Louisiana, Minnesota, Mississippi, New York, North Carolina, North Dakota, Texas, Washington, and Wyoming. These states each received 100 percent reimbursement for their first year PAM Project costs.

In the first year of the PAM Project (FY 2002), the nine participating states were given considerable flexibility in the design of their methodological approaches. Many states adopted similar approaches that were based on the Illinois, Kansas, and Texas studies. Some of the states built upon previous state initiated payment accuracy measurement studies. However, most of the states in the project attempted to address unique state concerns and circumstances.

During the first year of the project, CMS also contracted with The Lewin Group as the technical consultant to the PAM Project in order to work with the states and to help develop a single methodology that can be used by all states. Working collaboratively with the nine states, CMS and The Lewin Group developed the CMS PAM Model. The CMS PAM Model has been designed to estimate a state-specific payment accuracy rate that is within +/- 3 percent of the true population accuracy rate with 95 percent confidence. Moreover, through weighted aggregation, the state-specific estimates can be used to make national level payment accuracy estimates for the Medicaid and SCHIP programs.

In May 2002, CMS solicited states to participate in the second year of the PAM Project (FY 2003). Twelve states were awarded PAM grants to pilot test the CMS PAM Model. These 12 states include: Florida, Indiana, Louisiana, Mississippi, Nebraska, New York, North Carolina, North Dakota, Oklahoma, Texas, Washington, and Wyoming. Notably, 8 of these 12 states also participated in the first year of the project. Each of the 12 states is pilot testing the CMS PAM Model and, as in the first year of the project, each of these states will receive 100 percent reimbursement for all project costs.

Payment Accuracy Measurement

Simply defined, payment accuracy is the ratio of the dollar value of payments paid accurately to the dollar value of total payments made. The basic steps of payment accuracy measurement consist of:

1. draw a random sample of claims from each universe of paid Medicaid and SCHIP claims in the state;

2. subject that sample to review and audit to determine the validity of the payments made; and

3. compute an accuracy rate based on the sample, where the accuracy rate is defined as the ratio of the expected dollar value of payments paid accurately to the dollar value of total payments made.

The CMS PAM Model has been designed to estimate payment accuracy for both the FFS and MC components of the Medicaid and SCHIP programs. In the second year, seven states are pilot testing the Medicaid FFS component of the model, four states are pilot testing both the FFS and MC components of the model, and one state is pilot testing the MC component of the model. In the third year of the PAM Project, we are anxious to begin pilot testing the model in SCHIP as well as the Medicaid program.

In order to comply with the new requirements of the Improper Payments Information Act of 2002 and the definition of erroneous payments within this Act and the related guidelines from OMB, the CMS PAM Model has been modified for further pilot testing during the third year of the project. These modifications include estimating payment error attributable to both underpayments and ineligible recipients. The estimate of improper payments will be the gross total of both over- and underpayments. In addition, independent verification of eligibility will be

incorporated into the model through case reviews. The participating states in the project will select a random sub-sample of cases from the sample of paid claims/line items and review the cases to verify that the beneficiary was eligible for Medicaid or SCHIP services on the month/date of service or most recent determination or redetermination. These recent modifications to the model are being pilot tested in the Medicaid program by 7 of the 12 states participating in the project this year. In the third year of the project, we plan to pilot test all facets of the CMS PAM Model in both the Medicaid and SCHIP programs.

III. Demonstration Project: Third Year

This solicitation is for the third year of the PAM Project. In the third year, the goal is to further refine and pilot test the CMS PAM Model for both FFS and capitated MC Medicaid and SCHIP programs.

A. Who May Apply

Applications for the third year of the PAM Project will be accepted from three types of agencies: 1) the state Medicaid agency; 2) the state agency that administers SCHIP; or 3) the State Auditor, Comptroller or other state agency, in partnership with the state Medicaid agency. Third year participation is open to all states, regardless of participation in prior years of the project. States that participated in the first or second year of the PAM Project are encouraged to submit an application to participate in the third year.

For the purpose of this cooperative agreement, "state" is defined as each of the 50 states and the District of Columbia. See Part VI for specific information regarding the application process.

B. Duration of Awards

The award is for the third year of the PAM Project beginning September 30, 2003, and ending September 29, 2004.

C. Amounts and Timelines for Funding

CMS anticipates announcing the awards within 30 calendar days of receiving the applications. Applications are due no later than 60 calendar days from the date of this solicitation. The funding is for the period of September 30, 2003 through September 29, 2004. State participation in the PAM Project will be 100 percent Federally funded through a combination of FFP and HCFAC grant funding as reimbursement for what would otherwise be the state share. For the third year, CMS has $6.5 million in total HCFAC funds from which to award PAM grants to states.

The authority for this project is provided for under section 402(a)(l)(J) of the Social Security Act Amendments of 1967. States will report project costs up to the approved funding ceiling on the Notification of Grant Award on their quarterly Medicaid and SCHIP expenditure reports (Form CMS – 64.10 Waiver and Form CMS – 21 Waiver) at the applicable match rate, and receive the

Federal share through the standard grant award and draw down process. The HCFAC special grant funds will be paid through a separate draw down account established in the Payment Management System (PMS) for that purpose. The usage of these two funding mechanisms ensures that states will receive 100 percent Federal reimbursement for all PAM Project costs. The detailed financial proposal accompanying the application must demonstrate an understanding of the funding mechanism.

D. Uses of Funds

Funds may be used for payment of direct expenses associated with the demonstration project. The funds may be expended by government or other organizations or entities with the responsibility to perform the activities requested under the agreement. Examples of these direct expenses may include but are not limited to: designing and drawing the statistical sample, contractor-related expenses for auditing medical records, and the cost of retrieving records from various locations.

Funds under this initiative may not be used for services or consultants whose purpose is not related to this demonstration project. Funds may not be used for equipment purchase or overhead costs. The indirect costs may not exceed 9 percent.

E. Program Announcement

This Program Announcement describes the CMS PAM Model for FFS payments and for payments made under capitated MC. The model will be applied at the individual state level by the states, but will be capable of aggregation across states into a national measure. Hence, the method of payment accuracy measurement must be sufficiently consistent across states so that the aggregate measure makes sense, but sufficiently general so that each state can apply the method to its own unique circumstances. In Section 1 below, we describe the CMS PAM Model for FFS payments. In Section 2, we describe the CMS PAM Model for capitated payments under MC.

We have also conducted a review of SCHIP, authorized under Title XXI of the Social Security Act. Under Title XXI, the states chose to include SCHIP-eligible children either under a program that is an expansion of the state's Medicaid program in effect in 1997 (expansion) or as a separate program (SCHIP). We believe that the CMS PAM Model is applicable to both the Medicaid expansion and separate stand-alone SCHIP programs. As of 2002, 16 states have chosen to provide coverage to SCHIP-eligible children through Medicaid expansion, 16 states have chosen to provide coverage through a separate program, and 19 states have programs that combine a separate program and a Medicaid expansion.[1]

[1] This includes the 50 states and the District of Columbia, as of the most recent reporting period. Several states expanded Medicaid through Title XXI by accelerating the phase-in of the eligibility group for children under age 19 in families with income up to 100 percent of the Federal poverty level. As of October 1, 2002, all of these children have been phased-in; enrollment in Medicaid expansions or the Medicaid portion of combination SCHIP programs is expected to drop or cease entirely in certain states during this fiscal year.

The Improper Payments Information Act of 2002 and related OMB guidelines require Federal programs to report erroneous payment information with their annual budget submissions. Erroneous payments include both overpayments and underpayments, and payments to ineligible persons. Therefore, the specifications for the CMS PAM Model in FY 2003 have been modified to include estimation of payment error attributable to both underpayments and ineligibility.

The purpose of the PAM Project is to develop state level estimates of the accuracy of Medicaid payments and the accuracy of SCHIP payments. These state level estimates can then be aggregated into a national accuracy rate for Medicaid payments and a national accuracy rate for SCHIP payments. In this pilot project, states may choose to apply the CMS PAM Model to some or all of their Medicaid and SCHIP component programs. Those states which have both FFS and MC components to their Medicaid and/or SCHIP programs and who elect to apply the CMS PAM Model to both components are asked to produce an overall Medicaid or SCHIP rate as an appropriately weighted average of the relevant FFS and MC components.

1. Payment Accuracy Measurement Model: Fee-for Service Claims

In this section, we describe the CMS PAM Model and key features for FFS claims. The CMS PAM Model for FFS payments to providers is a straightforward one. Moreover, it is applicable to SCHIP FFS programs under Title XXI. Inaccurate payments can include both overpayments and underpayments.[2]

A. Key Components and Parameters

Below, we further define the key parameters of the FFS payment accuracy measure.

1. Universe

The "universe" of claims is the set of claims from which the sample is drawn, and the set of payments for which the accuracy rate is inferred from the sample. The Medicaid FFS claims universe, from which the sample is to be drawn, consists of all FFS Medicaid claims or invoices *paid* to providers in which FFP at Title XIX matching rates was claimed. That is, any claim paid for in part by Federal dollars should be included in the universe, or population, of claims to be sampled. The universe, however, excludes any non-claims based payments as well as disproportionate share payments, crossover claims, aggregate cost settlement payments, payments made by Medicaid to Medicare for Medicare Part B insurance, and any other expenditure that is not a payment to a provider for services provided for a beneficiary. It includes only payments made to providers of services. The universe will consist of paid claims only. Those denied in full, or returned to the provider because of submission errors, will not be

[2] Underpayments include those instances in which a provider's claim was improperly reduced by the Medicaid claims processing system, either manually or through the automated edits, and, upon re-review for the PAM Project, it is concluded that a higher payment was justified. The difference between the two amounts would be the underpayment. For example, if a provider submits a claim for the maximum allowable charge of $100 but the claims processing system pays only $50, and upon a PAM review of the medical records it is determined that the full $100 should have been paid, then the $50 difference will be considered an underpayment. On claims where the maximum allowable charge is less than the submitted charge but greater than the amount paid by the claims processing system, the difference between the maximum allowable charge and the paid amount is the underpayment.

sampled. Claims paid for a "zero" payment amount are also excluded. Adjustments to claims are also excluded from the universe. However, when a paid claim or line item is sampled, all adjustments to that line item that occur within 60 calendar days after the payment adjudication date for that line item should be included.[3]

The same general criteria for defining the "universe" are also applied to SCHIP. The SCHIP FFS claims universe, from which the sample is to be drawn, consists of all FFS SCHIP claims or invoices *paid* to providers for which SCHIP FFP was claimed. For FFS SCHIP programs that are a Medicaid expansion, the claims for children in the expansion group(s) are generally co-mingled with other Medicaid FFS claims. The SCHIP claims (for which FFP was sought) should be separated from Medicaid claims subject to Title XIX FFP and a separate accuracy rate for children in the expansion group(s) should be produced.[4] In addition, for FFS SCHIP programs that are a separate state program, the claims for the separate program should be considered their own universe. A separate sample should be drawn from this universe and a separate accuracy rate should be produced from this sample. However, the goal is to compute one overall SCHIP accuracy rate.[5]

2. Time Period for Sampling

The sample shall be drawn from a universe of all claims paid during the first quarter of the Federal fiscal year (FFY). That is, all paid claims for which payment was made between October 1 and December 31, inclusive, will be included in the universe for sampling purposes. The inference drawn from the sample regarding the payment accuracy rate, however, will be for the entire FFY, October 1 through September 30.

3. Sampling Unit

The sampling unit will be the "line item" or service. An actual claim may consist of several line items or services. As long as these line items can be independently priced, they will constitute the sampling unit. (Items simply listed as included in a bundled service would not be considered "line items" for this purpose.)

It is assumed that the state can sample at the "line item" or service level. Sample sizes and sampling plans are predicated on sampling at the line item level. If the state can draw samples only at the "claim" level—the submission by the provider with one or more line items on it—the state may choose to select and review all line items on the claims sampled. However, for sample

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[3] The state may choose to begin the review of a line item before the 60-day window for accepting adjustments is complete. However, if the state does this, it should discern whether any adjustment by the provider subsequent to beginning the review was triggered by the review itself. If so, it should not allow that particular adjustment for the purposes of computing the PAM model error rate.

[4] In some states, the number of beneficiaries enrolled in SCHIP programs is small. This suggests that sample size calculations should use the finite population correction.

[5] If the state has both an FFS SCHIP program that is a separate, stand-alone program and an FFS SCHIP program under Title XXI that is part of a Medicaid expansion, the state may draw two separate samples for the SCHIP accuracy rate—one from each source. However, it should combine the results into one overall SCHIP FFS accuracy rate by weighting the results from the two samples by the share of SCHIP expenditures represented by each.

size purposes, the claim itself will count only as one sampling unit, regardless of the number of line items reviewed on the claim.[6]

4. Sampling Plan

The overall sample size will be drawn to obtain an estimate of the payment accuracy rate that is within +/- 3 percentage points of the true population payment accuracy rate, with 95 percent confidence. These precision requirements apply to both Medicaid and SCHIP FFS samples. We anticipate that sample sizes necessary to achieve this level of precision will typically be greater than 800 line items.[7]

A proportional, stratified random sample will be drawn for Medicaid FFS. Stratification is not required for the SCHIP sample. The sampling strata will be by major provider categories defined as:

- inpatient hospital services;
- long-term-care services;
- other independent practitioners and clinics;
- prescription drugs;
- home and community-based services;
- other services and supplies; and
- primary care case management (PCCM), if applicable.[8]

Note: at the request of states participating in the FY 2003 PAM Project, PCCM payments are included in a separate stratum (previously, PCCM payments were included in the "Other Independent Practitioners and Clinics" stratum). Thus, if the state offers a primary care case management (PCCM) program, it should include the PCCM claims as a separate, seventh stratum. Appendix A provides a breakout of the services and supplies that map into each of the strata.

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[6] The accuracy of paid line items on a claim is not likely to be independent. That is, if one line item on a claim is found to have been paid in error, the probability that another item on the same claim is in error is greater than that for an item picked at random from another claim. Hence, the standard error of an estimate of the accuracy rate based on a sample of 1000 line items is likely to be greater if the sample size is made up of all the items on about 300 claims, compared to a sample where each of the 1000 line items is independent of the claim on which it appears. For this reason, we are reluctant to count more than one line item from a claim in determining sample size. Our recommended alternative of reviewing all line items on the claim but counting the result as only one sampling unit will "oversample" to some (unknown) extent, depending on the correlation of the accuracy of individual line items on a claim. However, to count all the line items from a single claim toward the same sample size is likely to overstate the information provided by the sample, compared to a sample of line items of the same size that is independently drawn.

[7] In the case of SCHIP, the population of beneficiaries and of claims in some states may be small. If so, the sample size calculation should take into account the finite population correction, because it may reduce the necessary sample size in some cases.

[8] This is to avoid a stratum where PCCM claims might be included (e.g., other independent practitioners and clinics) to be dominated by a large number of small PCCM claims. If the state has a PCCM program, but it is very small and its claims are not likely to dominate a stratum, the state may choose to include PCCM under the Other Independent Practitioners and Clinics stratum.

The sample sizes by stratum should be proportional to the dollar value of the line items represented by each stratum for the most recent four quarters.[9] That is, if inpatient hospital services represent 30 percent of the dollar value of total Medicaid claims, 30 percent of the sample of line items should come from the inpatient stratum. Note that this will result in oversampling in strata for which the proportion of Medicaid payments is greater than the proportion of Medicaid line items, and undersampling in those strata for which the proportion of line items is greater than the proportion of Medicaid payments. When calculating the payment accuracy rate, this over- and under-sampling by strata must be taken into account in calculating an unbiased estimate of the overall payment accuracy rate.[10]

For purposes of the eligibility review (a component of the processing validation review), a random sub-sample of cases from the sample of paid claims and/or line items will be selected. The sub-sample of beneficiaries should include at least 100 PAM beneficiaries derived from the sampled claims or line items. If the state will be applying the PAM model to both its FFS and its MC programs within Medicaid, at least 50 beneficiaries should be reviewed for eligibility from the FFS program and at least 50 beneficiaries should be reviewed from the MC program. That is, the total requirement of reviewing at least 100 Medicaid beneficiaries would be split evenly between the two Medicaid programs, if the state offers both programs and chooses to apply the PAM model to both.

The sub-sample will exclude cases where Medicaid eligibility is an automatic byproduct of eligibility for other programs. This includes the Social Security Administration for SSI recipients (in 1634 states), Title IV-E for adoption assistance/foster care cases, and the Office of Refugee Resettlement for refugee cases that are 100 percent Federally funded. In states where eligibility for Temporary Assistance for Needy Families (TANF) cash assistance confers automatic Medicaid eligibility, the state welfare agency determinations of eligibility for TANF/Medicaid cases are also excluded for purposes of the PAM eligibility review**.**

In the case of SCHIP, no eligibility populations are excluded, but the sub-sample sizes should be at least 100. If the state has several insurance programs in SCHIP and chooses to apply the model to two (or more), the state should allocate its total of 100 eligibility reviews evenly between the SCHIP insurance programs to which it is applying the PAM model. That is, if the state is calculating payment accuracy for both a FFS SCHIP program and a full-risk indemnity program (analogous to a capitated payment under MC), it would do at least 50 eligibility reviews in each, for a total of at least 100. If there are several separate programs, the state should aggregate the results into one overall SCHIP accuracy rate for the state.

B. Audit and Review

The review and audit should consist, at a minimum, of two components: processing validation and medical review.

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[9] This improves the precision of the estimate if the variance of the accuracy rate across strata is proportional to the Medicaid payment share represented by the stratum.

[10] In particular, if $W^{s,j}$ is the proportion of total sampled line items represented by stratum j, and $W^{u,j}$ is the proportion of total line items in the universe represented by stratum j, then each line item should be weighted by $W^{u,j}/W^{s,j}$ when calculating the accuracy rate.

1. Processing Validation

Once the sample is drawn, each line item should be reviewed to validate that it was processed correctly, based on the information that is on the claim. Specific issues to address in the review include:

- duplicate item (claim);
- non-covered service;
- service covered by HMO (i.e., beneficiary is enrolled in MC organization that should have covered the service);
- third party liability;
- invalid pricing;
- logical edits (e.g., incompatibility between gender and procedure);
- beneficiary eligibility (for sub-sample);
- data entry (clerical) errors;
- other.

The processing review should include a review of beneficiary eligibility in the month the service was provided for the selected sub-sample of at least 100 beneficiaries. We exclude cases where Medicaid eligibility is an automatic by-product of eligibility for another program. This includes the Social Security Administration for SSI recipients (in 1634 states), Title IV-E for adoption assistance/foster care cases, and the Office of Refugee Resettlement for refugee cases that are 100 percent Federally funded. In states where eligibility for Temporary Assistance for Needy Families (TANF) cash assistance confers automatic Medicaid eligibility, the state welfare agency determinations of eligibility for TANF/Medicaid cases are also excluded for purposes of the PAM eligibility review.

Eligibility reviews will determine whether the state's most recent Medicaid eligibility determination or redetermination was correct or, at the state's option, that the beneficiary was eligible for Medicaid in the month the sampled service was provided (or on the date of service in states with date-specific eligibility). This will include:

- review of the original eligibility case record materials (independent verification of information or documentation that appears to be valid is not required); and

- any third party verification, beneficiary interviews, or other inquiries necessary to complete and/or validate any discrepancies or omissions in the case record.

If the time between the most recent determination or redetermination of eligibility and the date of service for the relevant claim exceeds the state's policy regarding timely eligibility determination or frequency of redetermination, the review should determine the eligibility of the beneficiary in the month the service was provided. A similar procedure would be applied to the SCHIP sample. No beneficiaries will be excluded from the sample of at least 100 beneficiaries for the SCHIP review.

2. Medical Review

In addition, the line item should be subject to comprehensive medical review, which, as used here, will include at a minimum:

- review of the guidelines and policy related to the claim;
- review of medical record documentation;
- medical necessity review; and
- coding accuracy review.

Medical record documentation requests to providers via mail are sufficient for this process; states may, at their option, conduct scheduled or "surprise" visits to provider offices in order to collect medical record documentation.

When errors are found, the dollar amount of the payment error and the reason for the error should be recorded (to be included in the report). General guidelines for medical review of claims, along with reason codes for both processing and medical review errors, are included in Appendix B. The guidelines are relatively general and states are asked to adhere to the guidelines in their reviews, if possible. Please note instances, if any, where your own review is likely to deviate from the guidelines in your grant application.

C. Computation of the Payment Accuracy Rate for Fee-for-Service Claims

The payment accuracy rate can be computed in two ways. In both methods, the estimate is based on the gross total of overpayments and underpayments, as required by the Improper Payments Information Act of 2002.

The first method is a ratio estimate. In this method, the numerator of the ratio consists of the total dollar amount of sampled line items paid with both overpayments and underpayments subtracted. The denominator of the ratio is the total dollar value of sampled line items paid. If, upon review, the payment of a line item is reduced, but not fully denied, the reduced amount (the payment made less the overpayment) appears in the numerator. If, upon review, the payment of a line item is increased, the original payment less the increased amount appears in the numerator. For example, if there were $100 of paid line items sampled, and it was found that there were $10 in overpayments and $5 in underpayments, the accuracy rate would be 85 percent or ($100-($10+$5))/$100. Overpayments and underpayments do not "offset" each other, but combine into a total payment error.[11]

The accuracy rate, when there are K sampling strata, is given by:

[11] This is in accordance with the Improper Payments Information Act (P.L. 107-300) and implementing OMB guidance.

$$AccuracyRate = \frac{\sum_{j=1}^{K} \sum_{i=1}^{N_j} w_j (p^M_{,i,j} - (o_{i,j} + u_{i,j}))}{\sum_{j=1}^{K} \sum_{i=1}^{N_j} w_j p^M_{i,j}}$$

where P^M i is the dollar amount of the i^{th} paid line item in stratum j that was paid to a provider for the i^{th} line item in stratum j and "o" represents any overpayment while "u" represents an underpayment. The Wj's are the relevant weights for the strata applied to the items to account for over- and under-sampling. These weights, for each stratum, will be the ratio of the proportion of line items in the universe in that stratum to the proportion of line items in the sample represented by that stratum. The sample size is N, overall, with Nj line items in stratum j.

Under the alternative method, a difference estimate, we define F as the proportion of all the claims submitted in the period that are represented by the sample. For example, if 1 percent of all claims in the period were sampled, then F=.01. The estimated total dollar amount of accurate payments is given by the expression:

$$TotalEstimatedAdjustedPayments = \frac{\sum_{j=1}^{K} \sum_{i=1}^{N_j} w_j p^M_{i,j} - (o_{i,j} + u_{i,j})}{F}$$

Then, the accuracy rate is equal to:

$$AccuracyRate = \frac{TotalEstmatedPaymentsAdjustedforOverandUnderPayments}{TotalPayments}$$

Under both methods of estimation, the concept of the accuracy rate is the same:

$$AccuracyRate = \frac{ActualPayments - \{overpayments + underpayments\}}{ActualPayments}$$

The estimation of the accuracy rate for the SCHIP samples is similar, except that there are no strata. That is, the estimate would be modified as:

$$AccuracyRate = \frac{\sum_{i=1}^{N} w\ (p_{,i}^{M} - (o_i + u_i))}{\sum_{i=1}^{N} p_i^{M}}$$

where N is the sample size. A similar modification would apply to the difference estimate.

If the state, as part of the pilot project, were to estimate accuracy rates for two or more SCHIP FFS components (because, for example, the state had both a stand alone SCHIP FFS program and a FFS SCHIP program that was part of a Medicaid expansion), it should estimate an overall SCHIP accuracy rate as the weighted average of the separate rates.[12] The weights should represent the proportions or shares of total dollar value of the FFS SCHIP program represented by each component. For example, if the Medicaid expansion represented 40 percent of the total dollar value of the FFS SCHIP in the state, and a separate SCHIP FFS program represents 60 percent, then the overall SCHIP FFS accuracy rate would be obtained as the combination of the two:

$$SCHIPFee - for - ServiceRate = .4 * ExpansionRate1 + .6 * separateSCHIP$$

The standard error and 95 percent confidence interval should be computed for the estimated payment accuracy rate. We recognize that the assumptions underlying the computation of sample size required to achieve the desired level of precision may be not be realized in the actual sample drawn. Hence, the actual confidence interval calculated for the estimated payment accuracy rate may be different from the +/- 3 percent interval desired. However, the assumptions used in calculating the sample size should be conservative so that it is likely that the actual confidence interval will be +/- 3 percentage points or smaller.

An analytical estimate of the standard error for the ratio estimator can only be approximated. We recommend bootstrapping or related re-sampling techniques for estimating the standard error for the ratio estimate. An estimate of the standard error using the alternative method is straightforward, analytically.

D. Reporting

In reporting the estimated payment accuracy rate, the following information should be provided:

- the payment accuracy rate;[13]
- its standard error and 95 percent confidence interval;
- point estimates of rate by stratum (Medicaid);
- total sample size and sample size of each stratum (if applicable), measured by both number of items and dollar value;

[12] This assumes that the state chooses to participate in both of its FFS SCHIP programs.

[13] If there are two or more FFS programs for which the PAM model was applied, please provide both the individual rates and the combined (weighted) accuracy rates.

- proportion of dollars and proportion of items represented by each stratum (if applicable), both in the universe and in the sample;
- dollar distribution of errors by reason and by overpayments versus underpayments;
- projected estimate of total over and under payments for the period of inference; and
- findings and observations resulting from the analysis.

2. Payment Accuracy Measurement Model: Capitated Managed Care

A. Key Components and Parameters

1. Universe

Each state enrolling beneficiaries in fully- or partially-capitated MC enrollment options should include transactions determined by such arrangements within the scope of its payment accuracy measurement program. Monthly management fees paid to primary care physicians under a primary care case management (PCCM) program are not considered "capitation payments" within the meaning of this section. Such payments, however, should be considered as claims for the purpose of measuring FFS claims payment accuracy.

The "universe" is the set of payments for which the accuracy rate is inferred from the sample. The Medicaid capitated payments universe, from which the sample is to be drawn, consists of those payments described in sections B and C, *paid* to HMOs or providers for which there is FFP.

The "universe" for the children's insurance program authorized under Title XXI, for both Medicaid expansions and separate SCHIP programs where there is FFP, is analogous when the program is a capitated MC program. If the separate SCHIP program is a full-risk indemnity insurance program in which the state pays premiums on behalf of individual beneficiaries, substitute "premium payment" for "capitation payment" in the methodology below.

2. Time Period for Sampling

The sample shall be drawn from a universe of all claims paid over the first quarter of the FFY. That is, all paid claims for which payment was made between October 1 and December 31, inclusive, will be included in the universe for sampling purposes. The inference drawn from the sample regarding the payment accuracy rate, however, will be for the entire FFY, October 1 through September 30.

Transactions involving monthly capitation payments made on behalf of beneficiaries enrolled in health plans should be sampled directly, as described in Section B. Transactions involving FFS claims that are paid on behalf of beneficiaries who are enrolled in capitated MC will be assessed as described in Section C below.[14]

[14] This applies, also, to SCHIP programs if there is also a FFS counterpart.

B. Capitated Premium Payments

1. Sampling of Capitation "Claims"

States should treat a claim for a capitation payment made on behalf of an individual beneficiary for an individual month as a "line item" sampling unit for payment accuracy measurement. Only capitation payments actually paid by the state should be sampled. Capitation line items presented on rosters (or other media) by health plans to the states that were not actually paid during the sampling period should be excluded from the sampling frame.

The sample of capitation claims should be determined independently from the FFS claims sample, and should be drawn to obtain an estimate of the accuracy rate that is within +/-3 percentage points of the true population accuracy rate for capitation payments, with 95 percent confidence.

2. Audit and Review of Capitation Claims

Determinations regarding the accuracy of capitation payments made by states require discrete examination of two issues. First, reviewers must determine whether a capitation payment by the state to a specific health plan on behalf of an individual beneficiary for a given month was, in fact, warranted under the rules of the state's MC program. Second, in the event that a payment by the state to the health plan for that beneficiary is determined to be appropriate, reviewers must determine whether the proper amount of payment was actually made. The requirements for making both sorts of determinations are described in the following subsections.

3. Appropriateness of Capitation Payment

For each capitation claim drawn for payment accuracy measurement, reviewers must obtain information from the state's original MC eligibility and enrollment transaction records that is sufficient to determine whether payment should have been made by the state to that specific health plan on behalf of that specific beneficiary for that specific month. While the exact criteria under which proper enrollment are determined will require assessment of state-specific rules governing such transactions, the critical questions are:

- Was that specific beneficiary eligible for Medicaid in that month (for sub-sample)?
- Was that specific beneficiary eligible to be enrolled in *any* capitated MC arrangement in that month?[15]
- Was the beneficiary eligible to be enrolled in that specific health plan in that month?[16]
- Was the beneficiary actually enrolled in the health plan for that month, and eligible to receive services?[17]

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[15] In some states, eligibility for MC enrollment can vary depending on the place of residence or eligibility status of the beneficiary.

[16] In some states, eligibility for enrollments in specific health plans may be restricted to a subset of the population eligible for enrollment in other health plans.

Reviewers should analyze the information available from Medicaid eligibility and MC enrollment transaction records and make an independent determination of whether that enrollee was eligible to be enrolled, and actually enrolled, in a specific health plan in the month in question.[18] If that determination confirms the appropriateness of the beneficiary's enrollment in that plan in that month, further assessment of the capitation payment amount should be conducted under the procedure described in the following section. If the eligibility and enrollment determination made by reviewers contradicts the appropriateness of payment to that plan for that beneficiary for that month, the full amount of that monthly capitation payment should be determined to be an inaccurate payment.[19]

The determination that the Medicaid beneficiary for whom the capitated payment is made is eligible for Medicaid is based on a sub-sample of at least 100 beneficiaries, as described in the FFS discussion of eligibility determination. If the state chooses to test the PAM model for both its FFS and its MC Medicaid programs, at least 50 beneficiaries should be sampled from each, for a total of at least 100 beneficiaries for the purposes of eligibility review. Similarly, if the state applies the model to more than one SCHIP program, a total of at least 100 SCHIP beneficiaries should be sampled, and distributed evenly across the SCHIP programs included. The methods for validation of eligibility are also as described in the FFS discussion. One may start with the most recent, timely, determination or redetermination, independently documenting any missing or ambiguous information. However, in the case of MC capitation payments, states are encouraged to validate key eligibility requirements during the month for which the capitation payment is made, if possible.

4. Accuracy of Payment for Properly-Enrolled Beneficiaries

For each capitation payment that is determined under the procedure described above to have been made for a beneficiary who is properly enrolled in that plan for that month, reviewers should make a determination regarding the appropriate amount of payment that should have been made on that beneficiary's behalf. Employing the MC eligibility and enrollment information gathered in making the determination of appropriate enrollment, reviewers should make an independent determination of the specific capitation payment rate cell that should have been applied to that beneficiary's enrollment with that plan in that month, and the dollar amount that was appropriate for that rate cell.[20] If the state's capitation plan includes variation in payment based on medical or other criteria, the review should attempt to verify that the beneficiary has met the criteria. The reviewer should have sufficient clinical background to make this determination, should the payment system be based on clinical criteria. The amount determined to be the accurate payment amount should be compared to the amount of the actual payment

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17 Issues involved in assessing actual enrollment include the issuance of a membership card, and whether the beneficiary was enrolled with a specific primary care provider to deliver or authorize care.

18 See the description of eligibility review in the CMS PAM Model for FFS for more description of the requirements for the review of beneficiary Medicaid eligibility.

19 The determination of whether any payment is appropriate should turn on actual enrollment in a plan, even if that enrollment resulted from an administrative error that prevented an eligible beneficiary from being enrolled in some other plan of their choice.

20 If a state's payment methodology involves multiplying a base rate times a series of scalar factors to determine appropriate payment amounts, the term "rate cell" should be interpreted to include distinct premium amounts that result from the application of such factors.

recorded in the sampled transaction record. The amount of any difference between the determined amount and the actual amount should be recorded as an inaccurate payment.

C. Payment of Fee-for-Service Claims for Managed Care Enrollees

States reviewing the accuracy of monthly capitation payments are also required to assess whether any FFS claims were paid on behalf of beneficiaries during their period of enrollment in a capitated health plan, and whether such payments were accurate.

Concerns about the appropriateness of FFS payments arise when a claim is submitted for FFS payment for services that fall within the scope of services required, under the terms of the state's contract with a capitated plan, to be paid by the capitated plan. In addition to claims for services falling within the scope of full- or partially-capitated arrangements for general medical/surgical services, states may also have capitated arrangements with other benefits managers, e.g., capitated behavioral health contractors. The payment accuracy measurement process must assess the accuracy with which state systems prevent duplicate payments by denying FFS claims for services that fall within the scope of services required to be covered by capitated contractors. If a service falls within the scope of services covered under a capitated contract, a FFS claim payment should be determined to be inappropriate even if the capitated contractor has denied a claim for that service.

(The FFS claims that were erroneously paid to MC enrollees are based on the capitation MC sample. Hence, any inferences regarding the total errors made for the universe must be made based on an inference from the MC side. It would be incorrect to simply include them as errors in the FFS accuracy rate. On the other hand, any dollars in error from this source are FFS dollars, not MC capitation payments. Hence, the state is required to determine if FFS claims were erroneously paid for recipients in the MC sample who were validly enrolled in a MC plan. However, it should report the number and dollar value of any such errors separately, and not include them directly in the MC payment accuracy measure.)

1. Determination of Claims for Review

The state is required to evaluate FFS claims paid for services incurred during the month of enrollment for each enrollee determined, in the review conducted under Section B above, to be eligible for Medicaid and properly enrolled in a health plan for that month.[21] Reviewers should obtain, from the state's paid claims history, all of the FFS paid claims for services incurred on behalf of that beneficiary during the enrollment month.[22]

2. Determination Regarding Duplication of Coverage

Each FFS claim for a service that is determined to have been incurred during the period in which a beneficiary was actually enrolled in a capitated MC organization should be reviewed for appropriateness of FFS payment in light of the terms of the contract with the specific MC

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[21] Reviews of claims that may be covered by capitation arrangements that do not involve enrollment are discussed in subsection C.3.

[22] The state should review all paid claims for services incurred during this period, even if the claim was not paid until after the end of the period in which paid claims were sampled in the FFS model.

organization in which the beneficiary was properly enrolled. This determination should be made with regard to the explicit language of the contract between the state and that health plan, read together with any clarifying or interpretive documents available.

Where a determination regarding contractual coverage turns on clinical issues, that determination should be made in light of the findings of the medical record audit and review process described in the FFS model. If the review supports a determination that the claim was, in fact, covered within the scope of a capitated MC contract with a MC organization with which the beneficiary was actually enrolled, the full amount of the paid claim should be reported as an inaccurate payment.

3. Special Instructions Regarding Capitated Non-Enrollment Options

If a state makes capitated payments to MC contractors on a population-wide basis without regard to the enrollment of individual beneficiaries, the state should follow these special instructions for additional review of claims sampled in the FFS claims payment accuracy measurement process described in the FFS model. For the purposes of this section, a "capitated non-enrollment option" is defined as a program under which a state makes a capitation payment to a MC vendor to furnish a specified scope of services, such as behavioral health services, to all beneficiaries falling within a particular class, without requiring individuals to actively enroll with the contractor to receive services.[23] The purpose of this review is to determine, in a manner analogous to the review described above, whether any FFS claims have been paid that should have been denied by reason of their coverage under the scope of work of the MC contractor.

In preparing for the payment accuracy measurement program, reviewers should analyze the contract(s) between the state and any such contractor(s), and make a determination regarding the classes of claims that are clearly excluded from payment by the contractor(s) under the terms of the contract(s) in all relevant periods.[24]

As part of the review of FFS claims sampled under the FFS model, reviewers should determine whether that sample contains claims that fall within classes of services not explicitly excluded from payment under the terms of the capitated non-enrollment program. Each claim for a service that is determined not to be explicitly excluded from coverage under the state's capitated non-enrollment program(s) should be reviewed to determine whether that claim should have been paid by a contractor. If it is determined that a claim should not have been paid by the FFS claims processing system, the full amount of the claim should be reported as an inaccurate payment under the FFS model.

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[23] While such program options may commonly "enroll" beneficiaries in their case management programs once individuals are identified as needing such services, they would still be considered "non-enrollment options" as long as the capitation payments are made without regard to such "enrollments."

[24] For this purpose, the "relevant period" is date of service for those line items sampled in the FFS sample. The key issue is whether the beneficiary should have received the service under the (non-enrollment) MC agreement, rather than on a FFS basis.

D. Computation of the Payment Accuracy Rate for Capitated Managed Care

1. Capitated Payments

The CMS PAM Model for capitated MC should be estimated in a manner analogous to the FFS accuracy rate described in the previous section. The denominator should include the dollar value of all the capitation payments made in the sample. The numerator should include the dollar value of the payments, adjusted for overpayments and underpayments using the formulas used in the FFS model.

2. Fee-for Service Payment Made in Error

In addition, the review may reveal that FFS payments were made in error for some sampled beneficiaries covered under capitated MC agreements. If so, the dollar value of the FFS payments made in error for services provided during the period for which the beneficiary was covered under a MC agreement should be reported separately, and not be included directly in the accuracy rate.

E. Reporting

In reporting the estimated capitated MC payment accuracy rate, the following information should be provided:

- the payment accuracy rate;
- its standard error and 95 percent confidence interval;
- total sample size;
- dollar distribution of errors by over and under payments and by the following reasons:
  - — ineligible beneficiary
  - — incorrect payment amount
- FFS payments made in error-projected estimates of total over and under payments for the period of inference;
- findings and observations resulting from the analysis.

Finally, those states that choose to apply the PAM model to both their FFS and MC Medicaid programs should combine the results of the FFS accuracy rate analysis and MC accuracy rate analysis into one combined Medicaid rate. One can do this using either the "ratio" method or the 'difference" method discussed above. Under the ratio method, the combined Medicaid rate is a weighted average of the FFS and MC rates:

$$CombinedMedicaidRate = w_{ffs} MedicaidFFSAccuracyrate + w_{mc} MedicaidMCAccuracyrate$$

where the weights, "w", are the shares to total payments for the FFS program and MC program, respectively.

Using the "difference" method, the calculation would be:

$$CombinedMedicaidRate = \frac{TotalEstimatedAdjustedFFSPayments + TotalEstimatedAdjustedMCPayments}{TotalFFSPayments + TotalMCPayments}$$

IV. Review Criteria and Process

The state's proposal should contain an understanding of the problem, technical approach, management plan, and budget. Please respond to each of the numbered questions. The points associated with each section are described below. A total of 100 points may be awarded.

A. Understanding of the Problem 20 points total

The state must demonstrate an understanding of the purpose of payment accuracy measurement in Medicaid/SCHIP. The respondent should provide:

1. A statement that clearly indicates which of the CMS PAM Models the state is proposing to test: FFS and/or MC, for Medicaid and/or SCHIP. States are encouraged to propose participation in all models for which they have programs, but that is not required. The statement should also discuss the state's understanding of the requirements of the model.

2. A brief discussion of the strengths and weaknesses of the relevant CMS PAM Model(s) (FFS and/or MC). Address Medicaid and SCHIP, if applicable.

3. A brief discussion of the issues entailed in developing a national payment accuracy measure from state level estimates of accuracy rates.

B. Technical Approach 40 points total

A state proposing to implement the CMS PAM Model for FFS and/or MC payment accuracy measures should present its approach to implementing the model(s). If the state proposes to conduct payment accuracy measurement for Medicaid and SCHIP and anticipates differences in the approaches for the two studies, please explain the differences where applicable. The respondent should provide, for each model:

1. A description of how the state will develop the sample, including data sources and stratification if Medicaid FFS. For states proposing to use the FFS model, indicate whether the state will be able to sample at the line item level, and what alternative approach will be used if this is not possible for some or all types of claims.

2. A description of how the sample size will be determined in order to meet the required level of precision. If possible, provide an estimate of the overall sample size for each universe (e.g., Medicaid FFS, Medicaid capitated MC, SCHIP capitated MC).

3. A description of the audit, review, and other procedures the state will use to validate the claims and/or capitation payments. Indicate how this is consistent with the methods outlined in the core requirements of the CMS PAM Model(s) and the draft Guidelines (see Appendix B).

4. A list of any potential problem areas or issues and ways that risks or problems can be mitigated.

A state proposing optional features around the core requirements of the CMS PAM Model(s) should provide:

5. A description of the proposed optional features, the rationale for them, the expected benefits, and how the "value added" by these optional features may be determined from the pilot.

6. An explanation of how the optional feature proposed is in addition to, not a substitute for, the relevant feature of the CMS PAM Model(s), or an explanation of how the option still preserves the essential elements. (If, for example, the state proposes on-site reviews of medical records documentation rather than letter requests to the provider for documentation, the essential elements of the CMS PAM Model are obviously preserved.)

C. Management Plan 40 Points total

The state should describe how the project will be organized, staffed, and managed. If the state proposes to conduct payment accuracy measurement for Medicaid and SCHIP and anticipates differences in the approaches for the two studies, please explain the differences where applicable. The management plan should address the following:

1. Staffing/Contracting Approach 20 of 40 Points

The proposed demonstration project must be staffed by persons with the experience and skills necessary to conduct and participate in a Medicaid payment accuracy measurement study. States should coordinate internally if they are participating in both Medicaid and SCHIP PAM pilot tests. States may also choose to contract with external organizations to conduct parts of the review (e.g., create data extract and sample, conduct medical record review). The respondent should provide:

1. A description of how the project will be staffed and how staff will be organized. If relevant, describe how Medicaid and SCHIP PAM Models will be coordinated within the state. Please indicate the expected number of persons that will assigned to the project and the estimated amount of time that will be spent on each aspect of the project (expressed on a full-time-equivalent basis). For example, if eight nurses will conduct medical record reviews full-time for 3 months, indicate that 8 persons totaling 2 FTEs (8 persons x 3 months/12 months) will participate in this aspect of the project.

2. A summary of the scope of work for any aspects of the project to be contracted out (if the state plans to use contractors). Indicate whether the vendor has been selected (or, if not, the timeline for contracting), and describe the process for contract oversight.

3. A discussion of quality control within the demonstration project, including methods to ensure sample size is correct and drawn appropriately and that adequate structures are in place to promote consistency and accuracy in medical review.

2. Project Timeline and Level of Effort 20 of 40 points

The state should present a timeline for the year-long study to begin October 1, 2003. The timeline should be consistent with sampling claims paid in the period October 1 to December 31, 2003, and producing preliminary findings in the period April 1 to June 30, 2004, if possible. The state will provide quarterly progress reports 30 calendar days after the end of the each quarter (i.e., by January 31, April 30, and July 31, 2004), and a final report no later than 30 calendar days after the end of the fourth quarter (i.e., by October 31, 2004). In addition, the state should plan for two 1.5-day conferences in the Baltimore/Washington D.C. area, one midway through the project year and one near the end of the study.

The timeline should indicate (by month or by quarter):

1. Major activities, milestones, and deliverables (including all activities listed above).

2. How the staffing effort is allocated over the timeline.

D. Budget

The project budget will not be scored on a point system. Costs will be evaluated relative to the technical merits of the proposal. The CMS goal of the project is to attempt to fund at least 25 applications. Because the total budget for the project is constrained, costs for individual proposals will also be evaluated based upon achieving this goal. Using Budget Form SF-424A, provide an estimate of the aggregate expenditures expected to support the project approach and level of effort described above. If relevant, describe how the budget is allocated between Medicaid and SCHIP pilot models.

The budget should clearly delineate the costs associated with the core requirements of the CMS PAM Model(s) proposed. If the state proposes to test both the FFS model and the MC model, please attach a summary that separately identifies those costs, if possible. Similarly, if the state is proposing both SCHIP and Medicaid models, please identify the relevant costs for each. Shared costs may be noted. In addition, the costs associated with each optional feature to the core requirements of the model (if any are proposed) should be broken out separately.

V. General Provisions

The states must agree to the following:

A. Reporting

States receiving awards must agree to cooperate with any evaluation of the product of the work and to provide required information and reports in a format prescribed by CMS. States shall submit quarterly progress reports that are due 30 days after the end of the quarter. States shall also submit a final project report due 30 days after the end of the project; the final report may be submitted in lieu of the fourth quarter report.

B. Coordination and Meetings

States receiving awards will participate in the demonstration project team. Project Directors or other appointed representatives are expected to participate on scheduled conference calls with the demonstration project team and attend two PAM Project conferences. The PAM Project conferences will be held in the Baltimore/Washington DC area and will be used as a forum for team members to present project progress reports, discuss findings, and address administrative concerns.

C. Civil Rights

All award recipients under this agreement must meet the requirements of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; the Discrimination Act of 1975; and provisions of Title II, Subtitle A of the Americans with Disabilities Act of 1990.

VI. Applying for This Demonstration Project

A. Application Format

The application kit can be accessed electronically at:
www.cms.hhs.gov/researchers/priorities/grants.asp

B. Deadline for Submission

Applications are due no later than 60 calendar days from the date of the solicitation. Applications mailed through the U.S. Postal Services or a commercial delivery service will be considered on time if they are received in the CMS Grants Office or postmarked by the closing date. Submissions by facsimile (fax) transmission will not be accepted. A proposal not postmarked by the closing date will be considered late. Late proposals will not be considered and will be returned without review.

An original proposal should be sent with five copies to:

Centers for Medicare & Medicaid Services
OICS, Acquisition and Grants Group
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attn: Linda Bianco (410) 786-7080
Email: lbianco@cms.hhs.gov

VII. Additional Information

For additional information regarding this solicitation, please contact:

Payment Accuracy Measurement (PAM) Project
Finance, Systems and Budget Group
Center for Medicaid and State Operations
Mail Stop S3-13-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attn: Wayne A. Slaughter, Ph.D. (410) 786-0038
Email: wslaughter@cms.hhs.gov

APPENDIX A
STRATA DEFINITIONS FOR SAMPLING SERVICES

These service definitions correspond to the Medicaid Statistical Information System definitions.

Stratum 1: Hospital Services
- Inpatient hospital services

Stratum 2: Long-Term Care Services
- Nursing facility services
- Inpatient psychiatric facility services for individuals 21 and under
- Other mental health facility services for individuals 65 or older
- ICF/MR services
- Religious non-medical health care institutions

Stratum 3: Other Individual Practitioners, Clinics
- Outpatient hospital services
- Clinic services
- Physician services
- Other licensed practitioner services
- Physical/occupational/speech therapy, etc.
- Rehabilitative services
- Dental services
- Nurse midwife
- Nurse practitioner

Stratum 4: Prescription Drugs
- Separately billed prescribed drugs

Stratum 5: Home and Community-Based Services
- Home health services
- Private duty nursing
- Personal care services
- Hospice services
- Targeted case management services

Stratum 6: Other Services and Supplies
- Lab and X-ray services
- Transportation
- Other services
- Sterilization services
- Abortions
- Unknown

Stratum 7: Primary Care Case Management (PCCM) (if applicable)

APPENDIX B
MEDICAID PAYMENT ACCURACY MEASUREMENT MEDICAL REVIEW GUIDELINES

This document provides general guidelines for medical review for the Payment Accuracy Measurement types of services i.e., Inpatient Services, Long-Term Care Services, and Other Individual Practitioners and Clinics. The goals and processes apply to all areas and the medical review steps are delineated for each type of service. These guidelines were developed to provide a basic framework across all states for the medical review process. They should not replace your state guidelines if there are discrepancies.

1.0 Goals of Medicaid Payment Accuracy Measurement Medical Review

1. Identify inappropriate billing in an effort to improve the payment accuracy and decrease the receipt of bills for unnecessary services;
2. Assure that payment is made only for covered items and services as described in State Medicaid Guidelines;
3. Assure that services do not exceed the patient's medical needs; and
4. If fraudulent behavior is found, comply with fraud and abuse guidelines for referral to the appropriate area.

2.0 Recommended Medical Review Steps

1. At the beginning of the medical review process, existing policies and guidelines are researched. The reviewer should be familiar with:
    - Medicaid State Policy Manual
    - Data Analysis Statistics for the provider
    - Medical Necessity Criteria
    - Applicable Coding Rules
    - Literature searches
2. Claims and the medical records are reviewed and analyzed by a Registered Nurse.
3. Nurses review the medical records and determine medical necessity, reasonableness of the paid services under review, and appropriateness of the clinical setting.
4. Determinations are made based on State Medicaid Rules and Regulations.
5. During the medical review process, if the provider fails to submit the requested documentation within the prescribed time frame, deny the claim and/or adjust the claim accordingly. If the provider furnishes documentation that is incomplete (insufficient to support medical necessity), adjust the claim in accordance with your State Medicaid Payment Policy.
6. If payment errors are identified, an educational letter is prepared for the facility. It is recommended the educational letter should contain:

- Specific case examples and errors identified;
- Policy and guideline references and explanation;
- Cite medical necessity, documentation, and coding issues in the letter as indicated;
- The overpayment amount should be included in the letter; and
- Copies of the actual policies and guidelines are enclosed with the letter.

3.0 Specific Medical Review Guidelines by Type of Service:

3.1 Inpatient

Inpatient claims and the medical records are reviewed and analyzed by a Registered Nurse.

1. Nurses review the medical records and determine medical necessity and reasonableness of the paid services under review.
2. Determinations are made for:
   - Appropriateness of admission;
   - Continued stay review;
   - Appropriateness of acute setting; and
   - Appropriateness and accuracy of ICD-9-CM coding.
3. Determinations are made based on State Medicaid Rules and Regulations and medical necessity criteria

3.2 Long-Term Care Services

Long Term Care Service claims and the medical records are reviewed and analyzed by a Registered Nurse. Nurses review the medical records and determine medical necessity and reasonableness of the paid services under review. Determinations are made for:

1. Appropriateness of admission;
2. Continued stay review;
3. Level of care; and
4. RUGS-III codes if applicable.

Determinations are made based on State Medicaid Rules and Regulations and other sources submitted such as the Minimum Data Set (MDS).

3.3 Other Individual Practitioners and Clinics

Claims and the medical records are reviewed and analyzed by a Registered Nurse. Nurses review the medical records and determine the medical necessity and reasonableness of the paid services under review. Determinations are made for:

1. Medical record documentation substantiation of the services paid.
2. Medical necessity of the service is appropriate.

3. Appropriateness and accuracy of ICD-9-CM diagnosis coding and CPT procedure coding, and diagnosis supports the procedure code.

Note: Date discrepancies off by one or two days with medical record substantiation of services performed should be noted and not counted as a payment error.

3.4 Dental Services

Claims and medical records are reviewed and analyzed by a Registered Nurse or Dental Hygienist to determine the medical necessity and reasonableness of the paid dental services under review. Determinations are made for:

1. Presence of documentation to substantiate that the dental provider was a qualified Medicaid provider;
2. Presence of documentation to substantiate that the dental services billed were actually delivered;
3. Appropriateness and accuracy of coding/billing;
4. Presence of medical record documentation to substantiate that based on the patient's age, medical/dental condition and/or symptoms the dental services were medically necessary (e.g., sealants for children not adults, oral surgery procedures); and
5. Verification that the dental service, as provided, was in compliance with the state's coverage policies, should have been paid under the FFS program, and was not the responsibility of an MCO if applicable.

3.5 Pharmacy

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine the medical necessity and reasonableness of the paid pharmacy services under review. Determinations are made for:

1. Presence of documentation to substantiate that the drug was prescribed by a licensed provider;
2. Presence of documentation to substantiate that the prescription was filled (including ordered dosage and number or amount of drug) by the pharmacy;
3. Appropriateness and accuracy of NDC and/or local coding conventions utilized for billing;
4. Presence of medical record documentation that substantiates that diagnosis and medical necessity are present to support use of the prescribed drug; and
5. Verification that the drug should have been paid for by the FFS program and was not the responsibility of an MCO.

3.6 Home Health and Community Services

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine the medical necessity and reasonableness of the paid home health or community services under review. Determinations are made for:

1. Presence of documentation to substantiate that the service was prescribed by a qualifying Medicaid provider;
2. Presence of documentation to substantiate that the service provider was a qualified Medicaid provider;
3. Presence of documentation to substantiate that the service was actually delivered/provided to the patient in the amount billed (this may require telephonic contact with the member);
4. Appropriateness and accuracy of coding/billing;
5. Presence of medical record documentation to substantiate that based on the patient's diagnosis/medical condition and/or symptoms the service was medically necessary; and
6. Verification that the service, as provided, was in compliance with the state's coverage policies, should have been paid under the FFS program, and was not the responsibility of an MCO if applicable.

3.7 Durable Medical Equipment (note: these may fall into Stratum 5 or 6)

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine the medical necessity and reasonableness of the paid DME services under review. Determinations are made for:

1. Presence of documentation to substantiate that the DME was prescribed by a qualifying Medicaid provider;
2. Presence of documentation to substantiate that the DME provider was a qualified Medicaid provider;
3. Presence of documentation to substantiate that the DME was actually delivered/provided to the patient in the quantity billed (this may require telephonic contact with the member);
4. Appropriateness and accuracy of coding/billing;
5. Presence of medical record documentation to substantiate that based on the patient's diagnosis/medical condition and/or symptoms the DME was medically necessary; and
6. Verification that the DME, as provided, was in compliance with the state's coverage and rent/purchase policies, should have been paid under the FFS program, and was not the responsibility of an MCO if applicable.

3.8 Transportation Services

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine the medical necessity and reasonableness of the paid transportation services under review. Determinations are made for:

1. Presence of documentation to substantiate that the transportation provider was a qualified Medicaid provider;

2. Presence of documentation to substantiate that the transportation service was actually delivered/provided to the patient (this may require telephonic contact with the member);
3. Appropriateness and accuracy of coding/billing (mileage, mode of transport such as van/ambulance/cab/bus, activity level of patient such as ambulatory, wheelchair, bed bound, and appropriate destination);
4. Presence of medical record documentation to substantiate that based on the patient's diagnosis/medical condition and/or symptoms the service was provided at the appropriate level; and
5. Verification that the service, as provided, was in compliance with the state's coverage policies, should have been paid under the FFS program, and was not the responsibility of an MCO if applicable.

3.9 Managed Care Capitation

Claims and medical records are reviewed and analyzed by a Registered Nurse to determine if the capitated rate paid to the MC organization was paid in the correct amount. Determinations are made regarding:

1. Eligibility and enrollment of the member in the MCO during the time covered by the capitation rate;
2. Documentation to support that the member was assigned to the appropriate capitation rate cell/adjusted risk group if applicable (age/sex/diagnosis); and
3. Capitation rate was paid in accordance with state capitation payment policies.

4.0 Request for Medical Record Information

The medical review information for all types of service is requested via a letter, sent by certified mail, to the facility. A time limit should be established for receipt of the medical records. Thirty (30) days is a suggested time frame. The medical record request letter should contain an explanation of the Payment Accuracy Measurement Project and a listing of the sample. It is recommended the sample listing include:

- The patient's name;
- The patient's Medicaid number;
- The patient's date of birth; and
- The date(s) of service.

The medical record documentation request should specify the description of records, for all that apply to your state, as follows:

4.1 Inpatient

- Pre-authorization form if applicable
- Face sheet to include coding for hospital stay

- Complete billing listing of all charges, payments, or adjustments for the hospital stay (Example: Account Ledger/Billing Statements)
- Physician's orders and progress notes
- Operative Reports
- Pathology Reports
- Anesthesia Records including pre and post -op
- Admission History and Physical
- Nurse's Notes
- Medication Records
- All Laboratory and X-ray Reports
- Cardiovascular, Procedure/Reports (EKG, Stress test, Echo etc.)
- All Flow Sheets (including vital sign records)
- Nursing Care Plan and/or Critical Pathways
- Consultation Reports
- Discharge Summary
- Any ER Notes related to the admission
- Hospital Transfer Form (if applicable)
- PT/OT/SLP Progress Notes (including charts for daily therapy, and documentation of therapy minutes)
- Any Additional Documentation that demonstrates the medical necessity of the services or procedures performed
- Name and Telephone Number of the Contact Person for Facility

4.2 Long Term Care Services

- Medical Eligibility Request Form
- Signed Minimum Data Set (MDS) – All that apply
- Documentation for look back periods (this may be prior to requested dates of service)
- Physician's orders and progress notes: hospital if applicable and NFS
- History and Physical Reports
- Nurse's notes for the NFS
- Medication sheets
- All flow sheets, including vital sign records and weight charts
- Nursing care plan

- Consultation reports
- Discharge summary
- Hospital transfer form
- PT/OT/SLP Progress Notes, including charts for daily therapy, and documentation of therapy minutes
- All treatment plans and therapeutic goals, including objective and subjective findings to support continuing treatment
- Any additional documentation that demonstrates the medical necessity of the service performed
- List of any abbreviations or symbols used and their meanings
- The name and telephone number of the contact person in your facility

4.3 Other Individual Providers and Clinics

- Office notes
- Procedure reports (if applicable)
- Operative reports
- Emergency Room records (if applicable)
- Physician's orders and progress notes (if applicable)
- History and Physical Reports
- Consultation reports
- Discharge summary (if applicable)
- Laboratory reports (if applicable)
- X-ray reports (if applicable)
- Pathology reports (if applicable)
- Nurses' notes
- Nursing home notes (if applicable)
- Cardiovascular, Procedure/Reports (EKG, Stress test, Echo, etc.)
- Treatment plan
- Immunization records
- List of any medications given
- Anesthesia records (including pre- and post-anesthesia)
- Any additional documentation that demonstrates the medical necessity of the services provided

4.4 Dental

- Dental claim
- Applicable Medicaid policies for dental coverage
- Medical record from attending dental provider
- Dental x-rays, molds, etc. if applicable
- Prior authorization documentation if applicable

4.5 Pharmacy

- Pharmacy claim
- Prescription
- Applicable Medicaid policies for prescription drug coverage to include formulary with NDC codes and MCO coverage policies
- Medical record from prescribing physician if policy or medical necessity question
- Prior authorization documentation if applicable
- Member pharmacy signature log if applicable

4.6 Home and Community Services

- Medicaid claim
- Medicaid policies and procedures associated with the provision of home health and community services
- Prior authorization documentation if applicable
- Complete billing listing of all charges, payments, or adjustments for the services (Example: Account Ledger/Billing Statements)
- Member services signature log if applicable
- OASIS data if applicable
- Physician's orders
- History and Physical and/or hospital discharge summary if appropriate
- Intake/initial assessment
- Nurse's Notes (including documentation of nursing time/minutes)
- Nurse's Aid/Personal Care Attendant Notes
- Personal care assistant notes and documentation of time/minutes if applicable
- Medication Records
- All Flow Sheets (including vital sign records)
- Nursing Care Plan/Case Management Plan

- Consultation Reports
- Discharge Summary
- Hospital Transfer Form (if applicable)
- PT/OT/SLP Progress Notes (including charts for daily therapy, and documentation of therapy minutes)
- Respiratory Therapy Progress Notes
- Infusion Therapy Notes
- Dietary/Nutrition Notes
- Any additional documentation that demonstrates the medical necessity of the services provided
- Name and telephone number of the member/contact person for the member
- Name and telephone number of the contact person for home health agency

4.7 Durable Medical Equipment

- DME claim/invoice
- Certificate of Medical Necessity
- Applicable Medicaid policies for DME coverage
- Medical record from prescribing physician
- Prior authorization documentation if applicable
- Member DME signature log or signed receipt if applicable

4.8 Transportation

- Provider claims corresponding to date of transport
- Transportation claim
- Transportation provider's account ledger/billing statements
- Transportation scheduling log
- Transportation Log with member signature if applicable
- Medical record from provider corresponding to transportation date to verify enrollee's ambulatory status and medical necessity for transportation

4.9 Managed Care

- Claims history to verify rate cell diagnoses
- Medical record from PCP/specialist to verify diagnosis/condition is present that placed patient in the capitation rate cell if applicable (e.g. HIV, pregnancy, special needs child)

5.0 PAM ERROR CODES AND HIERARCHY

The validation should consist of, at a minimum, two components: processing validation and medical review. It is recommended that the processing validation be performed first and that if errors are identified and payment was inappropriate for the line item then the second component – medical review is not performed. This approach may reduce the level of effort. The level of staff performing the processing validation is at the discretion of the state. It is recommended that Registered Nurses perform the medical review portion of the validation. Both over payment and under payment errors should be recorded.

5.1 Processing Validation Error Codes

- P1 - Duplicate item (claim) – an exact duplicate of the claim was paid – same patient, same provider, same date of service, same procedure code, and same modifier.
- P2 - Non-covered service – policies indicate that the service is not payable by Medicaid
- P3 - MCO covered service – the beneficiary is enrolled in a MC organization that should have covered the service and it was inappropriate to bill Medicaid.
- P4 - Third party liability – inappropriately billed to Medicaid.
- P5 - Pricing error – payment for the service does not correspond with the pricing schedule
- P6 - Logical edit – a system edit was not in place based on policy or a system edit was in place but was not working correctly and the claim line was paid.
- P7 - Ineligible recipient—the recipient was not eligible for the services or supplies.
- P8 - Data entry errors – there were clerical errors in the data entry of the claim.
- P9 - Other – if this category is selected a written explanation is required in the comment section beside the category.

5.2 Medical Review Error Codes

- MR1 – No documentation submitted – the line is unsupported due to no response to the documentation request.
- MR2 – Insufficient documentation submitted – the line is unsupported due to insufficient response to documentation request. Information was submitted by the provider, but it either was for the wrong date of service or did not support the procedure code billed.
- MR3 – Coding error – the procedure was performed but billed using an incorrect procedure code.
- MR4 – Unbundling – billing components of procedure codes when only one procedure code is appropriate.

- MR5 – Medically unnecessary service – medical review indicates that the service is medically unnecessary based upon the documentation of the patient's condition in the medical record.
- MR6 – Administrative error – medical review indicates an administrative error, such as an incorrect decision on a previous medical review or other administrative errors as designated by the state. This error may or may not result in a payment error.
- MR7 – Policy violation – a policy is in place regarding the service or procedure performed and medical review indicates that the service or procedure is not in agreement with the documented policy. An inappropriate diagnosis for a service or procedure, as documented in the policy, would also fall into this error code.
- MR8 – Other - if this category is selected a written explanation is required in the comment section beside the category.

If there is more than one error within the processing or medical review components, dollars should be allocated to the errors to reflect the dollars reduced or denied for the claim, in the order in which the errors are discovered. For example, if the claim or line items is denied 100 per cent for processing reasons, there would be no requirement to request documentation for medical review of the claim or line item.

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